

**CALIFORNIA ACUPUNCTURE BOARD**  
**REQUEST FOR CONTINUING EDUCATION (CE) COURSE APPROVAL FORM**  
[Must be in English (C.C.R., Title 16, Division 13.7, Section 1399.484)] - **Please Print or Type**

***ON-SITE EDUCATION***

Name of Provider Organization \_\_\_\_\_ CE Provider No. \_\_\_\_\_

Address \_\_\_\_\_

Name of CE Coordinator \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Course Title \_\_\_\_\_

Name of Lecturer(s) \_\_\_\_\_ Requested No. of CEUs \_\_\_\_\_

Course Date(s) and Location(s) \_\_\_\_\_

Has the above course been approved by the Acupuncture Board within the past two years? ☐ Yes ☐ No

(All courses must be approved each time the provider is offering it.)

If yes, is the current course content, number of CEUs, and lecturers identical as presented in the past? ☐ Yes ☐ No

Will this course be offered only in English? ☐ Yes ☐ No

If no, indicate other language(s) and describe translation arrangements.

Will the translation be performed simultaneously? ☐ Yes ☐ No

Will there be any publicity or advertisement for these courses? ☐ Yes ☐ No

If yes, please submit a copy of the publicity/advertisement for the Boards review with refund policy clearly stated.

By signing below, I affirm, under penalty of perjury, under the laws of the State of California, that I have read and will comply with the continuing education regulations and that all statements contained in this application are true and correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Title \_\_\_\_\_

***For Acupuncture Board's Use Only***

☐ **APPROVE** ☐ **DENY**

Course within 45-day timeframe ☐ Yes ☐ No

Course application complete ☐ Yes ☐ No

Herbal disclosure attached ☐ Yes ☐ No

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

## HERBAL DISCLAIMER

Will the instructor(s) be discussing treatments utilizing herbs or herbal formulas or introducing new herbs or formulas? ☐ No ☐ Yes

If yes, the provider of the course must be able to confirm that the herbs that will be discussed in this course/seminar are only those that are permitted by the California Department of Health and that formulas will contain herbs at different levels/portions that will not cause adverse health effects.

I confirm that the above information is true -

PRINT NAME

SIGNATURE

**TITLE**

DATE \_\_\_\_\_



## ONSITE COURSE OUTLINE

NAME OF COURSE \_\_\_\_\_

Please provide the course outline and include information on how this course relates to the scope of practice of acupuncture in California. Use additional sheets if necessary.

[illegible]

## ONSITE COURSE SCHEDULE

Please provide a breakdown of topics that will be covered during each day of the onsite course. When counting the number of CE Units, use the standard hour (60 minutes) for each CE unit (lunches may not be considered for CE units).

Starting and ending times:

| From  | - | To    | Topics to be covered during this time: |
|-------|---|-------|--|
| _____ | - | _____ | _____                                  |
|       |   |       | _____                                  |
| _____ | - | _____ | _____                                  |
|       |   |       | _____                                  |
| _____ | - | _____ | _____                                  |
|       |   |       | _____                                  |
| _____ | - | _____ | _____                                  |
|       |   |       | _____                                  |
| _____ | - | _____ | _____                                  |
|       |   |       | _____                                  |
| _____ | - | _____ | _____                                  |
|       |   |       | _____                                  |
| _____ | - | _____ | _____                                  |
|       |   |       | _____                                  |
| _____ | - | _____ | _____                                  |
|       |   |       | _____                                  |
| _____ | - | _____ | _____                                  |
|       |   |       | _____                                  |
| _____ | - | _____ | _____                                  |
|       |   |       | _____                                  |

**INSTRUCTOR INFORMATION**  
**[A separate 'Instructor Information' Sheet must be completed for each instructor]**

Instructor's Name \_\_\_\_\_

Complete Section 'A' if the instructor is an acupuncturist; otherwise, go to Section 'B':

**Section A:**

Is the instructor a California licensed acupuncturist? ☐ Yes ☐ No

If yes - License No. \_\_\_\_\_

If no, is the acupuncturist authorized to act as a guest acupuncturist in accordance with Section 4949 of the Business and Professions Code? ☐ Yes ☐ No

Is the instructor free of any disciplinary order or probation imposed by the Board? ☐ Yes ☐ No

Is the instructor knowledgeable, current and skillful in the subject matter of the course as evidenced through one of the following:

1. Possess a baccalaureate or higher degree from a college/university and provided written documentation of experience in the subject matter ☐ Yes ☐ No

Degrees Earned:

From [Name of the Educational Institution]

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Documents experience in teaching similar subject matter content within the two years preceding the course ☐ Yes ☐ No

3. Documents experience of at least one year (within the last two years) in the specialized area in which he or she is teaching. ☐ Yes ☐ No

**Section B:**

If the instructor is a non-acupuncturist, does he or she meet **all** of the following requirements?

1. Is currently licensed or certified in his or her area of expertise, if appropriate ☐ Yes ☐ No

Title of License or Certificate

License Number and Name of State

\_\_\_\_\_

\_\_\_\_\_

2. Provided written evidence of specialized training, which may include, but not be limited to, a certificate of training or an advanced degree in a given subject area. ☐ Yes ☐ No

3. Provided evidence of at least one year documented teaching experience within the last two years in the specialized area in which he or she teaches. ☐ Yes ☐ No

**ATTENDANCE RECORD**  
(Must be submitted within ten (10) days of course completion)

\_\_\_\_\_  
Continuing Education Provider (CEP) Name

\_\_\_\_\_  
CEP Number

**Date(s) of Course:** \_\_\_\_\_

**Name of Course:** \_\_\_\_\_

**CE Hours/Credits:** \_\_\_\_\_

**Instructor Name:** \_\_\_\_\_

| Printed Name | Signature | License No. | CEUs  |
|--------------|-----------|-------------|-------|
| _____ /      | _____     | _____       | _____ |
| _____ /      | _____     | _____       | _____ |
| _____ /      | _____     | _____       | _____ |
| _____ /      | _____     | _____       | _____ |
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| _____ /      | _____     | _____       | _____ |
| _____ /      | _____     | _____       | _____ |

**VERIFIED BY:** \_\_\_\_\_  
Instructor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

## PARTICIPANT EVALUATION FORM

\_\_\_\_\_  
**CE Provider Name and Number**

\_\_\_\_\_  
**Date(s) of Course**

\_\_\_\_\_  
**Course/Seminar Title**

\_\_\_\_\_  
**Instructor Name**

\_\_\_\_\_  
**Participant's Name and License Number**

\_\_\_\_\_  
**Date of Evaluation**



**Did this course meet its stated objectives?**

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**Did the instructor demonstrate adequate knowledge of the course subject?**

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**Did the instructor utilize appropriate teaching methods?**

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**Do you feel that you will be able to apply what you have learned today to your practice?**

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**Would you recommend this course to other licensed acupuncturists?**

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**Additional Comments:**

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## CERTIFICATE OF COMPLETION

THIS IS TO CERTIFY THAT \_\_\_\_\_ AC # \_\_\_\_\_, HAS SUCCESSFULLY COMPLETED \_\_\_\_\_ HOURS  
OF APPROVED CONTINUING EDUCATION.

PROVIDER NAME: \_\_\_\_\_

PROVIDER NO.: \_\_\_\_\_

\_\_\_\_\_  
COURSE TITLE

\_\_\_\_\_  
COMPLETION DATE

\_\_\_\_\_  
COURSE LOCATION

\_\_\_\_\_  
INSTRUCTOR'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PROVIDER'S AUTHORIZED SIGNATURE

\_\_\_\_\_  
DATE

CALIFORNIA LICENSED ACUPUNCTURISTS ARE REQUIRED TO RETAIN THIS CERTIFICATE FOR AT LEAST FOUR (4) YEARS FROM  
THE DATE OF COMPLETION OF THIS COURSE.